mouth open. Most recently, Gurumnik\(^1\) suggested a modification, which again depends on inserting the anesthesiologist's fingers into the patient's mouth. We wish to express our concern that this technique may expose the intubator to additional unnecessary risk of infection.

It is known that dentists may acquire hepatitis by contact with their patients' saliva. With hepatitis, herpes simplex, and now human T-cell lymphotropic virus type III (HTLV III) becoming endemic in the population, there is all the more reason to abandon this technique. Because most of us would take secretory precautions when dealing with known carriers of these and other potentially transmissible agents, we are at greater risk from the probably much greater population of undiagnosed carriers than from those known to harbor such infections.

Because opening of the mouth in the anesthetized, paralyzed patient is usually easily accomplished by extension of the alanto-occipital joint with the patient's head in the modified Jackson position and because this places the patient's airway in a position anatomically favorable for tracheal intubation, we feel that the inserting of fingers into the patient's mouth should be abandoned. Care must be taken to avoid entrapment of the patient's lower lip between the laryngoscope blade and lower dentition. That can easily be accomplished by slight caudal pressure on the patient's chin, a maneuver that also helps to open the mouth. If, in a rare case, placement of fingers in the mouth is unavoidable, one should wear gloves, as do our gynecologic and proctologic colleagues when digitally examining the genitalia or rectum. In our hospital we now stock single-use nonsterile gloves in the anesthesia carts.

By the same token, the routine daily use of either prescription eyeglasses or plain glass spectacles during the conduct of anesthesia should probably be encouraged to avoid the risk of inoculation of our conjunctiva with potentially infectious airborne saliva or blood.

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REFERENCE


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Solving a Difficult Intubation

To the Editor—When a difficult or impossible oral tracheal intubation arises and the directly visualized oral approach is unsuccessful, alternative techniques include blind nasal, retrograde, and fiberoptic-assisted. We report the use of these techniques combined.\(^1\)

A 48-yr-old, 90-kg man scheduled for coronary artery bypass surgery was anesthetized with nitroglycerin, iv, pancuronium bromide, 10 mg, and fentanyl, 50 \(\mu g/kg\). Ventilation was controlled, and \(F_{1O_2}\) was 1.0.

Oral endotracheal intubation attempts with Macintosh\(^3\) #3 and #4 and Miller\(^4\) #2 and #3 blades\(^5\) were unsuccessful because we could not visualize the vocal cords. Attempts at blind oral and nasal intubation also failed. A fiberoptic bronchoscope was then used but was impossible to insert because the trachea was too anterior. A 16-g needle was placed through the cricothyroid membrane into the trachea.\(^6\) An angiography catheter exchange guide wire (260 cm length and 0.035 in diameter) was directed cephalad through the needle and retrieved from the pharynx with forceps. Two more attempts to pass the endotracheal tube (8.0 mm ID, National Catheter Co.) over the wire were unsuccessful. We then placed the endotracheal tube over the fiberoptic bronchoscope and threaded the angiography wire retrograde through the suction port of the scope. We were able to direct the fiberoptic bronchoscope into the trachea and subsequently slide the endotracheal tube into position above the carina. It took 35 min from the time of induction to accomplish the intubation.

This combined new technique for difficult intubation may be preferable to tracheostomy as long as ventilation and hemodynamics are stable during intubation efforts. Anticipated complications are the same as with any technique that risks cricothyroid membrane puncture. This modification may be preferred to retrograde technique because tube placement is confirmed by direct visualization.

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References


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ANNOUNCEMENT

The American Board of Anesthesiology (ABA) will administer its first written examination in Critical Care Medicine on Saturday, September 27, 1986, in Boston, Massachusetts, and Dallas, Texas. Diplomates of the ABA who apply and are judged to be qualified by virtue of their additional training or experience in Critical Care Medicine will be accepted for examination. An application may be requested by writing to the Secretary, American Board of Anesthesiology, 100 Constitution Plaza, Hartford, Connecticut 06103. The deadline for receipt of completed applications in the Board office has been extended to May 31, 1986.